Regulation 28: REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

The Chief Executive, the Sussex Community NHS Foundation Trust

1 CORONER

I am Bridget Dolan QC, Assistant Coroner for West Sussex

2 CORONER'S LEGAL POWERS

I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

3 INVESTIGATION and INQUEST

On 05 November 2019 I commenced an investigation into the death of Gemma Elizabeth Azhar aged 37. The investigation concluded at the end of the inquest on 11 February 2020. The conclusion of the inquest was that Gemma Azhar died by suicide.

4 CIRCUMSTANCES OF THE DEATH

On 9 August 2109 Gemma Azhar had self-referred to the Sussex Community NHS Foundation Trust's 'Time to Talk' service ('TTT'). During a brief telephone call on 15 August 2019 Gemma Azhar informed a TTT duty worker that she had long term anxiety and depression and was currently experiencing acute distress in the context of marital problems and had previously been seen by her local CMHT. Gemma Azhar was offered a telephone assessment appointment with TTT in a month's time (on 16 September 2019).

On 16 September 2019 Gemma Azhar's appointment was cancelled by TTT. It is not clear why this appointment was cancelled but it may have been that there had been an error in the booking process and no therapist was available. An administrator spoke to Gemma Azhar informed her of the cancellation and offered a further assessment appointment on 30 September 2019.

On 30 September 2019 Gemma Azhar's assessment appointment was cancelled for a second time by TTT due to the designated therapist being unwell. Gemma Azhar was informed of this second cancellation in a telephone call made by an office administrator. A further assessment appointment was offered which Gemma Azhar declined. As the communication with Gemma Azhar was through an administrator no questions were asked of Gemma Azhar as to how she was feeling or why she was now declining the offer of a third date for an assessment. Gemma Azhar was then discharged from the TTT service.

Although a duty therapist was on duty on 30 September that therapist was not asked to speak to Gemma Azhar. Therefore, no assessment of Gemma Azhar's current mental state or her current level of risk was attempted before she was discharged from the service.

On the evening of the 31st October 2019 Gemma Azhar was found hanging in the garage at her home address.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:

Those in need of the TTT service and support may feel discouraged from engaging with the service and be

left at risk in the community if, when repeated cancellations occur, they are spoken to only by an office administrator, who is not in any position to enquire about their mental health or make any assessment of their current condition.

Indeed [redacted], the Clinical Lead for the Time to Talk service in the North Area, of gave evidence at Gemma Azhar's inquest and informed me that in her view, the service "did not get it right". She stated that given that the TTT service had cancelled Ms Azhar's apppointment twice, it would have been preferable if there had been attempts made to find her an alternative therapist on 30 September 2019 and, if none was available, for a duty worker to have spoken to Gemma Azhar before she was discharged from the service in order to understand: the reasons for her now declining a third appointment; her current mental state and, if appropriate, seek to engage her and assess her present risk.

[redacted] informed me that it was now the 'formal' position that this should happen after a second cancellation by the service. However, it is a matter of concern to me that staff working in the North area (Horsham, Crawley and Mid Sussex) have only been notified of this 'formal position' by an email sent in or around December 2019. This procedure is not part of any written policy or protocol or induction training and therefore new staff in the North area would only learn of the procedure by word of mouth. Furthermore, [redacted] was not aware whether or not a similar instruction had been given to the Sussex Community NHS Foundation Trust's staff working for the TTT service in other areas.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by April 07, 2020. I, the coroner, may extend the period.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

8 COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: [redacted] (parents) and [redacted] (Ms Azhar's husband).
I have also sent it to [redacted], the Clinical Lead for the Time to Talk service in the North Area, who may find it useful or of interest.

I am also under a duty to send the Chief Coroner a copy of your response.

The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response about the release or the publication of your response by the Chief Coroner.

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Bridget Dolan QC
Assistant Coroner for West Sussex,

Bridget DOLAN, QC

Assistant Coroner for
West Sussex Coroner's Service
Dated: 11/02/2020
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